

**TARGETED IMMUNE MODULATORS PA FORM**



**Fax Completed Form to:  
866-254-0761  
For questions regarding this  
Prior authorization, call  
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving a new prescription for Actemra, Orencia, Humira, Enbrel, Amevive, Kineret, Cimzia, Remicade, Simponi and Stelara must submit a prior authorization form.

- Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed below.

**Part I: TO BE COMPLETED BY PHYSICIAN**

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name					
Physician Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
<b>Requested Drug and Dosage:</b> <input type="checkbox"/> ORENCIA <input type="checkbox"/> AMEVIVE <input type="checkbox"/> ENBREL <input type="checkbox"/> CIMZIA <input type="checkbox"/> KINERET <input type="checkbox"/> REMICADE <input type="checkbox"/> HUMIRA <input type="checkbox"/> SIMPONI <input type="checkbox"/> STELARA <input type="checkbox"/> ACTEMRA			<b>FDA Approved Indication for this request:</b>		
<input type="checkbox"/> <i>I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</i>					
Physician Signature				Date	

**Part II: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

**Part III: FOR OFFICIAL USE ONLY**

Date Received			Initials:		
Approved - Effective dates of PA: From:     /     / To:     /     /			Approved by:		
Denied: (Reasons)					